U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 22 September 2006

In the Matter of
Mr. O. R. H.[1]
Claimant

Case No.: 2005 BLA 5418

v.

BLUE STAR COAL CORPORATION
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. Joseph E. Wolfe, Attorney
For the Claimant

Mr. Russell Vern Presley, II, Attorney
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER –
AWARD OF BENEFITS

This matter involves a claim filed by Mr. O. R. H. for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"), as implemented by 20 C.F.R. Parts 718 and 725. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

[1]Despite 20 C.F.R. § 725.477(b) ("A decision and order shall contain . . . the names of the parties . . . ."), and over my specific objection, Chief Administrative Law Judge John Vittone has directed that I substitute initials for the names of the Claimant and all family members. Any comments or concerns regarding this mandated practice should be directed to Chief Administrative Law Judge John Vittone, 800 K Street, Suite 400N, Washington, D.C. 20001.

Procedural Background

First Claim

Mr. H. filed his first application for black lung disability benefits on March 29, 1971 with the Social Security Administration ("SSA"). Upon completion of a pulmonary examination and several chest x-ray interpretations, SSA denied Mr. H.'s claim on December 1, 1973. SSA determined that while Mr. H. might have pneumoconiosis, it had not advanced to the complicated pneumoconiosis stage. Additionally, because Mr. H. was still working as a coal miner, he was not totally disabled. On September 18, 1974, after reviewing the record, Administrative Law Judge Jean R. Reed denied Mr. H.'s claim because his mild obstructive pulmonary defect did not establish the presence of disabling pneumoconiosis. On January 10, 1975, the Appeal Council affirmed Judge Reed's denial. Following amendments to the Act, Mr. H. elected to have his claim reconsidered by the U.S. Department of Labor ("DOL"). After another pulmonary examination, on June 22, 1981, DOL denied Mr. H.'s claim for failure to establish the presence of pneumoconiosis and total disability. (DX 1).[2]

Second Claim

On December 29, 1987, Mr. H. filed his second claim for black lung disability benefits. The claim was denied by DOL on August 25, 1988 because Mr. H. failed to prove the presence of pneumoconiosis and total disability. Upon reconsideration on August 15, 1990, DOL concluded Mr. H. had pneumoconiosis. However, the evidence remained insufficient to establish total disability. Following Mr. H.'s appeal, DOL forwarded his claim to the Office of Administrative Law Judges ("OALJ") on November 29, 1990. On October 4, 1991, Administrative Law Judge Frank J. Marcellino conducted a hearing. On February 7, 1992, Judge Marcellino denied Mr. H.'s claim because he could not prove total disability. Mr. H. appealed on February 28, 1992. On June 30, 1993, the Benefits Review Board ("Board" and "BRB") affirmed Judge Marcellino's denial of benefits. (DX 2).

Third Claim

On September 11, 1995, Mr. H. filed another claim. On July 23, 1996, after concluding that Mr. H. had pneumoconiosis and was totally disabled, the District Director denied the claim because the medical opinion failed to show that he was totally disabled due to coal workers' pneumoconiosis. Following Mr. H.'s appeal, the District Director sent the claim to OALJ on December 4, 1996. On April 29, 1997, Administrative Law Judge Richard A. Morgan conducted a hearing. On August 14, 1997, Judge Morgan denied Mr. H.'s claim. Although Mr. H. proved the presence of pneumoconiosis, Judge Morgan found the medical record insufficient to establish total disability. Mr. H. appealed the adverse decision on August 28, 1997. On September 2, 1998, the BRB affirmed the denial of benefits. Mr. H. appealed on October 5, 1998. Due to "failure to prosecute," Mr. H.'s appeal was dismissed by the U.S. Court of Appeals for the Fourth Circuit on December 21, 1998. (DX 3).

[2]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

Fourth Claim

On February 1, 2001, Mr. H. filed his fourth claim. On November 21, 2002, the District Director denied Mr. H's claim. Although Mr. H.'s was totally disabled due to a pulmonary impairment, he did not have pneumoconiosis. (DX 4).

Fifth and Present Claim

On January 8, 2004, Mr. H. filed his fifth claim for black lung disability benefits (DX 6). On September 27, 2004, the District Director determined Mr. H. was entitled to black lung disability benefits (DX 33). The Employer appealed on October 4, 2004 (DX 35). As a result, the District Director initiated interim benefits and forwarded the case to OALJ on December 28, 2004 (DX 40). Pursuant to a Notice of Hearing, dated April 13, 2005, (ALJ I), I conducted a hearing on July 26, 2005 with Mr. H., Mr. Wolfe, and Mr. Presley. My decision in the case is based on the hearing testimony and the following documents admitted into evidence: DX 1 to DX 42, CX 1, CX 2, and EX 1 to EX 4.

ISSUES

1. Timeliness of subsequent claim.

2. Whether in filing a subsequent claim in January 2004, Mr. H. has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement upon which the denial of his most recent prior claim was based in November 2002.

3 If Mr. H. establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Preliminary Findings

Born on December 12, 1935, Mr. H. married Ms. G. C. on September 4, 1956. Mr. H. started working in the coal mines, hand loading coal, when he was 19 years old. His spent his last five and a half years as a coal miner working for Blue Star Coal in Kentucky. During that period, Mr. H. was a belt man and engaged in heavy labor cleaning the area around the coal belt. Mr. H. stopped mining in August 1986 when the mine shut down. Mr. H. smoked cigarettes for about 20 years at the rate of half a pack to one pack of cigarettes a day. He stopped smoking cigarettes about 1970 (DX 1, DX 2, DX 3, DX 4, and TR, pages 18 to 37).

Stipulations of Fact

At the July 26, 2005 hearing, the parties stipulated that Mr. H. was a coal miner with post-1969 coal mine employment and that Mrs. G. H. is a dependent for the purposes of augmenting any benefits that may be payable under the Act (TR, pages 8 and 9).

Additionally, at an informal conference on July 19, 1990, the Employer's representative stipulated that Mr. H. had at least 24 years of coal mine employment and that Blue Star Coal Company is the responsible operator (DX 2).[3]

Issue #1 – Timeliness

In the September 2005 closing brief, Employer's counsel asserts Mr. H.'s present, subsequent claim should be denied as untimely because the claim was not filed within three years of receiving a medical determination that he was totally disabled due to pneumoconiosis as required by applicable law. Counsel asserts Mr. H.'s earlier claims are "replete with medical reports" dating from 1987 to 1996 from Drs. Forehand, Sutherland, and Modi, documenting "their opinions that claimant had coal workers' pneumoconiosis and was totally disabled by that process."

According to the Benefit Review Board[4] and as recently determined by the U.S. Court of Appeals for the Fourth Circuit,[5] the three year statute of limitations does not apply to subsequent claims filed under 20 C.F.R. § 725.309. However, because Mr. H. left his home in Virginia and crossed the state line to mine coal in Kentucky, his case falls under the jurisdiction of the U.S. Court of Appeals for the Sixth Circuit.[6] Unlike the BRB and the neighboring federal circuit appeals court, U.S. Court of Appeals for the Sixth Circuit applies the three year statute of limitations to subsequent claims. *Tennessee Consol. Coal Co. v. Kirk,* 264 F.3d 602 (6th Cir. 2001).[7]

Section 422(f) of the Act, 30 U.S.C. § 932(f), and its implementing regulation, 20 C.F.R. § 725.308(a), require that a claim for must be filed within three years of a medical determination of total disability due pneumoconiosis being communicated to the claimant. In considering the application of this statute of limitations, 20 C.F.R. § 725.308(c) also provides a rebuttable presumption that every claim for benefits filed under the Act is timely filed. To rebut the presumption of timeliness, an employer must show that a medical determination satisfying the statutory definition was communicated to the miner more than three years prior to filing his claim. *See Sturgill v. Bell County Coal Corp.*, ____ B.L.R. _____, BRB No. 05-0343 BLA (May

[3]Mr. H.'s hearing testimony and employment records, including the payroll statement from Blue Star Coal Company, DX 2, also establish that Blue Star Coal Company is the responsible operator.

[4]*Dempsey v. Sewell Coal Co.,* 23 B.L.R. 12-47 (2004) (en banc).

[5]*Consolidation Coal Co. v. Director, OWCP [Williams],* ___ F.3d ___, Case No. 05-2108 (4th Cir. July 13, 2006).

[6]The location of the claimant's last coal mine employment establishes the jurisdiction of federal court of appeals. *Shupe v. Director, OWCP,* 12 B.L.R. 1-200, 1-202 (1989) (en banc).

[7]I note that in an unpublished decision, *Peabody Coal Co. v. Director, OWCP [Dukes],* Case No. 01-3043 (6th Cir. Oct. 2, 2002 (unpub.), the court held that the statute of limitations is not triggered by a medical determination submitted in conjunction with a prior claim that was ultimately denied. However, in *Furgerson v. Jericol Mining, Inc,* BRB Nos. 03-0798 BLA and 03-798 BLA-A (Sept. 20, 2004) (unpub.), the BRB determined that published *Kirk* opinion rather than the unpublished *Dukes* decision controls the statute of limitation issue for black lung subsequent claims in the U.S. Court of Appeals for the Sixth Circuit.

30, 2006) (en banc) (McGranery dissenting). The requisite medical determination must be a "reasoned opinion by a medical professional." *Kirk*, 264 F.3d at 607; *cited in Sturgill,* BRB No. 05-0343.

Under these principles, and due to the presumption of timeliness under 20 C.F.R. §725.308(c), denial of a black lung disability claim due to un-timeliness under 20 C.F.R. § 725.308(a) has two components. First, an employer must demonstrate that a physician informed a claimant more than three years prior to date of his black lung disability claim that he was totally disabled due to pneumoconiosis. Second, the total disability medical determination must be supported by a reasoned medical opinion. Accordingly, since Mr. H. filed his most recent claim on January 8, 2004, I must examine the record to determine whether a reasoned medical determination of total disability due to pneumoconiosis was communicated to Mr. H. prior to January 8, 2001.

Dr. V. D. Modi

On January 9, 1987, Mr. H.'s treating physician, Dr. Modi, conducted a pulmonary evaluation. Both the pulmonary function tests and the arterial blood gas studies were near normal. Referencing a positive September 1986 chest x-ray, Dr. Modi diagnosed coal workers' pneumoconiosis and COPD (chronic obstructive pulmonary disease). The physician also noted that Mr. H. struggled with "low back pain." Dr. Modi concluded that Mr. H.'s "condition curtails him not to expose himself to coal dust, fumes or noxious gases." The physician also noted Mr. H. could no longer crawl, squat, or lift heavy objects. As a result, Dr. Modi concluded Mr. H. was totally and permanently disabled.

According to Mr. H.'s hearing testimony in October 1991 (DX 3) and July 2005 (TR, page 34), Dr. Modi was the first physician to tell him that he was totally disabled. Around 1986, Dr. Modi gave him a report indicating that he had 2/2 pneumoconiosis. The doctor told him to get out of the mines due to his breathing problems. Mr. H. recalls, "He told me to quit, that's all I know. He said 'it's time to quit, you got too much dust.'"

In light of Mr. H.'s recollection, the first component of communication to the claimant has been established. However, for two reasons, I find Dr. Modi's medical opinion is not a medical determination of total disability due to pneumoconiosis. First, Dr. Modi believed Mr. H. was incapable of coal mining in part because he should no longer be exposed to coal mine dust. While that advice may make both common and medical sense, the presence of black lung, standing alone, does not render a miner totally disabled from any further coal mine employment under the Act and regulation. Instead, total disability means the inability to perform to the physical labor associated with coal mining due to a pulmonary impairment. Second, and closely related, although Dr. Modi noted several physical constraints which precluded Mr. H.'s work as a coal miner, the doctor did not also specifically attribute Mr. H.'s physical limits to any pulmonary condition or impairment. Since the physician noted Mr. H.'s low back pain, Dr. Modi's imposed physical restrictions could simply reflect Mr. H.'s bad back condition. Further, the absence of a pulmonary impairment causation determination by Dr. Modi is consistent with the pulmonary testing he conducted. Neither the pulmonary function tests nor the arterial blood study showed a pulmonary or respiratory insufficiency. Accordingly, since Dr. Modi did not

provide a medical determination of total disability due to pneumoconiosis, his communication to Mr. H. did not trigger the three year statute of limitations.

Dr. Harvey A. Page

On January 13, 1987, after a pulmonary evaluation that did not show total disability, Dr. Page advised Mr. H. not to return to coal mining due to the presence of pneumoconiosis in his lungs. Since Dr. Page's recommendation was not based on a totally disabling pulmonary impairment, his opinion did not initiate the three year statutory filing requirement.[8]

Dr. Robert W. Penman

Following a January 24, 1987 pulmonary examination of Mr. H., Dr. Penman diagnosed coal workers' pneumoconiosis and opined that his lung function was impaired. Dr. Penman did not indicate whether Mr. H.'s impaired lung function would preclude his return to coal mining. Additionally, the record contains no evidence that Dr. Penman told Mr. H. that he was totally disabled due to pneumoconiosis. Consequently, Dr. Penman's January 1987 pulmonary evaluation did not start the statute of limitations.

Dr. Frank J. Sutherland

In letters, dated May 16, 1996 and January 31, 1997, Dr. Sutherland informed Mr. H.'s attorney that Mr. H. was totally disabled due to coal workers' pneumoconiosis. In his opinion, Mr. H.'s condition had worsened. In the April 29, 1997 hearing, DX 3, Mr. H. testified that Dr. Sutherland has been his treating physician since the 1970s. He regularly visited Dr. Sutherland, who prescribed breathing medication.

For two reasons, the limited information concerning Dr. Sutherland's total disability determination renders his opinion an insufficient statute of limitations trigger. First, notably absent is any evidence that Dr. Sutherland communicated his total disability determination to Mr. H. Certainly, a reasonable assumption may be made that during the course of his treatment of Mr. H., Dr. Sutherland stated his conclusion to Mr. H. However, neither Dr. Sutherland, nor more importantly, Mr. H. have specifically stated if and when such a communication occurred. Also, considering the nature of black lung litigation and the relationship between an attorney and his client, another reasonable assumption may be made that sometime during the course of these proceedings, Mr. H. became aware of Dr. Sutherland's total disability opinion. However, these reasonable assumptions are an insufficient basis to overcome the regulatory presumption that Mr. H.'s present claim is timely. Considering the harsh consequences associated with invocation of the three year statute of limitation, the record must contain evidence of Dr. Sutherland's communication of his total disability determination <u>to</u> Mr. H.

Second, and more significantly, besides Dr. Sutherland's terse conclusions in his correspondence to Mr. H.'s counsel, no record of his treatment of Mr. H. has been placed into evidence. Consequently, I am unable to ascertain whether Dr. Sutherland's total disability

[8]Eleven years later, upon review of the pulmonary tests, Dr. Page concluded Mr. H. retained the pulmonary capacity to return to coal mining.

determination was reasoned. Accordingly, the record evidence fails to establish that Dr. Sutherland's total disability determination triggered the three year statute of limitations.

Dr. Emory Robinette

1991 Evaluation

Upon completion of a January 31, 1991 pulmonary evaluation, Dr. Robinette advised Mr. H.'s attorney that Mr. H. had coal workers' pneumoconiosis and was totally disabled due to a "significant pulmonary impairment," DX 2. The chest x-ray was positive for pneumoconiosis, the pulmonary function study showed a mild obstructive impairment, and the arterial blood gas study revealed mild resting hypoxemia. Recognizing that the "degree of functional impairment proven at spirometry (pulmonary function test) is felt to be mild with mild resting hypoxemia," Dr. Robinette suggested that a stress test be conducted.

In addition to insufficient evidence that his total disability determination was communicated to Mr. H., Dr. Robinette's 1991 evaluation fails to trigger the statute of limitations because it is not reasoned. Specifically, Dr. Robinette failed to explain how the pulmonary tests results, which showed only a mild impairment, supported his conclusion that Mr. H. had a significant pulmonary impairment. Dr. Robinette explicitly acknowledged that deficiency by recommending a stress test. Notably, when a stress test was conducted a few months later on August 8, 1991, DX 2, it also showed only a mild respiratory impairment.

1997 Evaluation

After conducting a pulmonary examination on March 27, 1997, Dr. Robinette again advised Mr. H.'s lawyer that Mr. H. was totally disabled due to coal workers' pneumoconiosis. The chest x-ray was positive for pneumoconiosis, DX 3. The pulmonary function test showed a moderate pulmonary impairment.

Although the March 1997 pulmonary tests support Dr. Robinette's total disability finding, his examination results were reported to Mr. H.'s counsel and not Mr. H. The Act's statute of limitations, as enforced by *Kirk,* is predicated on communication of medical determination of total disability to the claimant. For the purpose of denying his subsequent claim because Mr. H. failed to satisfy the statute of limitations, I believe imputing his attorney's knowledge of Dr. Robinette's total disability determination to Mr. H. seems inappropriate since Mr. H., rather than his counsel, bears the personal responsibility to file a black lung disability benefits claim within three years of his receipt of a physician's determination of total disability due to pneumoconiosis.

Dr. J. Randolph Forehand

On October 3, 1995, on behalf of DOL, Dr. Forehand evaluated Mr. H.'s pulmonary condition. The chest x-ray was positive for pneumoconiosis. The pulmonary function tests revealed a partially reversible pulmonary obstruction. The exercise arterial blood gas study met

the regulatory total disability threshold. Based on his evaluation, Dr. Forehand concluded Mr. H. was totally disabled due to coal workers' pneumoconiosis.

Dr. Forehand's finding is an insufficient statute of limitations trigger because the record contains no evidence that his determination was directly communicated to Mr. H.

Conclusion

Since Mr. H. filed his first claim for black lung disability benefits over 35 years ago, several physicians have concluded that Mr. H. either had impaired lung function or should no longer work as a coal miner due to the presence of pneumoconiosis in his lungs. Due to several factors, either separate or combined, none of the physicians' statements satisfy the statute of limitations trigger event – the communication to Mr. H. of a determination of total disability due to pneumoconiosis based on a reasoned medical opinion. Accordingly, Employer's motion to dismiss Mr. H.'s fifth claim for black lung disability benefits due to un-timeliness must be denied.

Issue #2 – Change in Applicable Condition of Entitlement

After the expiration of one year from the denial of benefits, the submission of additional material or another claim is considered a subsequent claim and adjudicated under the provisions of 20 C.F.R. § 725.309(d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present. 20 C.F.R. § 725.309(d)(3). If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309(d)(4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed after the prior adjudication supports a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

To receive black lung disability benefits under the Act, a claimant must prove four basic conditions, or elements, related to his physical condition. First, the miner must establish the presence of pneumoconiosis.[9] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in

[9] 20 C.F.R. § 718.202.

part, out of coal mine employment.[10] Third, the miner has to demonstrate he is totally disabled.[11] And fourth, the miner must prove the total disability is due to pneumoconiosis.[12]

Based on those four principle conditions of entitlement, the adjudication of a subsequent claim involves the identification of the condition(s) of entitlement a claimant failed to prove in the prior claim and then an evaluation of whether through newly developed evidence a claimant is able to now prove the condition(s) of entitlement. Mr. H.'s most recent prior claim was denied in November 2002 because he failed to prove the presence of pneumoconiosis. Consequently, for purposes of adjudicating the present subsequent claim, I will evaluate the evidence developed since the record closed in 2002 to determine whether Mr. H. can now prove the presence of pneumoconiosis in his lungs.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[13] The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease. . .arising out of coal mine employment."[14] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b). As several courts have noted, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202(a)(1)), autopsy or biopsy report (§ 718.202(a)(2)), regulatory presumption (§ 718.202(a)(3)),[15] and medical opinion (§ 718.202(a)(4)). Since the record does not contain any evidence that Mr. H. has complicated pneumoconiosis, and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. Additionally, Mr. H. has not submitted a biopsy. As a result, Mr. H. will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis.

[10]20 C.F.R. § 718.203(a).

[11]20 C.F.R. § 718.204(b).

[12]20 C.F.R. § 718.204(a).

[13]20 C.F.R. § 718.201(a).

[14]20 C.F.R. § 718.201(a)(1) and (2) (emphasis added).

[15]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202(a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

Chest X-rays

Date of x-ray	Exhibit	Physician	Interpretation
March 15, 2004	DX 14	Dr. Patel, BCR, B[16]	Positive for pneumoconiosis, profusion category 1/1,[17] type s opacities.[18] Emphysema present.
(same)	DX 17	Dr. Wheeler, BCR, B	Negative for pneumoconiosis. Possible emphysema present.
June 10, 2004	EX 3 & EX 4	Dr. Fino, B	Negative for pneumoconiosis. Possible infectious granulomatous present.
February 7, 2005	CX 1	Dr. Patel, BCR, B	Positive for pneumoconiosis, profusion category 2/1, type s opacities. Emphysema present.
(same)	EX 1 & EX 2	Dr. Wheeler, BCR, B	Negative for pneumoconiosis. Possible emphysema present.

Based on Dr. Fino's sole and uncontested interpretation, I find the June 10, 2004 chest x-ray is negative for pneumoconiosis.

In the March 15, 2004 and February 7, 2005 radiographic films, Dr. Patel, a dual qualified radiologist, found sufficient profusion to support a finding that the chest x-rays were positive for pneumoconiosis. However, Dr. Wheeler, also a dual qualified radiologist, found no evidence of pneumoconiosis. Their professional standoff concerning the extent of the profusion renders the March 15, 2004 and February 7, 2005 chest x-rays inconclusive for the presence of pneumoconiosis.

Since one of the three films is negative for pneumoconiosis (June 10, 2004) and the other two radiographic studies are inconclusive (March 15, 2004 and February 7, 2005), Mr. H. is

[16]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

[17]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1. According to 20 C.F.R. § 718.102(b), a profusion of 0/1 does not constitute evidence of pneumoconiosis.

[18]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

unable to prove the presence of pneumoconiosis through chest x-rays under 20 C.F.R. § 718.202(a)(1).

Medical Opinion

Although Mr. H. cannot establish the presence of black lung disease through chest x-ray evidence, he may still prove this requisite element of entitlement under 20 C.F.R. § 718.202(a)(4) through the preponderance of the more probative medical opinion. To better evaluate the diverse medical opinion, a review of the other objective medical evidence in the present claim is helpful.

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV_1 pre[19] post[20]**	**FVC pre post**	**MVV pre post**	**% FEV_1 / FVC pre post**	**Qualified[21] pre post**	**Comments**
DX 14	March 15, 2004 Dr. Rasmussen	68 69”	1.60 1.90	3.73 3.95	--	44% 48%	Yes[22] No	
EX 3	June 10, 2004 Dr. Fino	68 69”	1.61 1.92	3.23 3.49	--	50% 55%	Yes No	
CX 1	Feb. 7, 2005 Dr. Rasmussen	69 69”	1.27 1.61	3.34 3.89	--	38% 41%	Yes[23] Yes	

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**$_pCO_2$ (rest) $_pCO_2$ (exercise)**	**$_pO_2$ (rest) $_pO_2$ (exercise)**	**Qualified**	**Comments**
DX 14	March 15, 2004 Dr. Rasmussen	36 39	69 58	No[24] Yes[25]	

[19]Test result before administration of a bronchodilator.

[20]Test result following administration of a bronchodilator.

[21]Under 20 C.F.R. § 718.204(b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner’s age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[22]The qualifying FEV1 number is 1.85 for age 68 and 69” the corresponding qualifying FVC and MVV values are 2.37 and 73, respectively.

[23]The qualifying FEV1 number is 1.82 for age 69 and 69”; the corresponding qualifying FVC and MVV values are 2.35 and 73, respectively.

[24]For a pCO^2 of 36, the qualifying pO^2 is 64, or less.

EX 3	June 10, 2004 Dr. Fino	38.2	72.7	No[26]	
CX 1	Feb. 7, 2005 Dr. Rasmussen	38 42	70 57	No Yes[27]	
CX 2	May 18, 2005 Dr. Castle	38.8 35.1	71.7 56.6	No Yes[28]	

Dr. D. L. Rasmussen
(DX 14 and CX 1)

March 15, 2004 Examination

On March 15, 2004, Dr. Rasmussen, board certified in internal medicine, examined Mr. H., who had been a coal miner for nearly 30 years and smoked a half a pack of cigarettes from 1953 to 1970. He complained about chronic shortness of breath. During the physical examination of Mr. H.'s chest, Dr. Rasmussen noted markedly reduced breath sounds. The chest x-ray was positive for pneumoconiosis. The pulmonary function tests revealed a partially reversible, moderate to severe pulmonary obstruction. With light exercise, the arterial blood gas study disclosed a moderate impairment in oxygen transfer.

Based on Mr. H.'s 29+ years of coal mine employment and the positive chest x-ray, Dr. Rasmussen diagnosed coal workers' pneumoconiosis. Dr. Rasmussen also diagnosed COPD (chronic obstructive pulmonary disease) and emphysema. Due to his moderate loss of pulmonary function, Mr. H. no longer had the pulmonary capacity to return to coal mining. His totally disabling impairment was due to both pulmonary risk factors: 8 pack years[29] of cigarette smoking and over 29 years of exposure to coal mine dust. Both pulmonary risk factors can cause lung damage that leads to emphysema.

February 7, 2005 Examination

On February 7, 2005, Dr. Rasmussen conducted a second pulmonary evaluation. Mr. H. had been a coal miner for 32 years. In his last job as miner, Mr. H. engaged in heavy to very heavy manual labor as a belt man. He smoked cigarettes for 15 years at the rate of one half pack per day. Mr. H. complained about long term shortness of breath. Upon physical examination, Dr. Rasmussen heard markedly reduced breath sounds. The chest x-ray was positive for pneumoconiosis. The pulmonary function tests showed a partially reversible, severe pulmonary obstructive defect. Although the resting arterial blood gas study at rest was minimally hypoxic, upon exercise, Mr. H.'s blood oxygenation became moderately impaired.

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[25]For a pCO^2 of 39, the qualifying pO^2 is 61, or less.

[26]For a pCO^2 of 38, the qualifying pO^2 is 62, or less.

[27]For a pCO^2 of 40 to 49, the qualifying pO^2 is 60, or less.

[28]For a pCO^2 of 35, the qualifying pO^2 is 65, or less.

[29]A pack year equals the consumption of one pack of cigarettes a day for one year.

Based on Mr. H.'s history of coal mine employment and the positive chest x-ray, Dr. Rasmussen diagnosed clinical pneumoconiosis. Mr. H. also had chronic obstructive pulmonary disease/emphysema. Mr. H. was totally disabled due to a pulmonary impairment. Dr. Rasmussen attributed the impairment to both cigarette smoking, which was minimal, and coal mine dust exposure, which was significant. While some studies indicated no distinction can be made on the effects of these two pulmonary hazards, Dr. Rasmussen believed Mr. H.'s exposure to coal mine dust was a significant cause of his pulmonary impairment due to the following three factors: a) a pulmonary obstruction; b) reduced diffusion capacity; and, c) significant impairment of blood oxygenation upon exercise. Finally, Dr. Rasmussen noted that the distinct improvement of pulmonary function with the use of a bronchodilator "suggests an element of hyperactive airways disease consistent even with bronchial asthma."

Dr. Gregory J. Fino
(EX 3 and EX 4)

On June 10, 2004, Dr. Fino, board certified in pulmonary disease and internal medicine, evaluated Mr. H.'s pulmonary condition. Mr. H. mined coal for 32 years and smoked a half a pack of cigarettes for 15 years. In his last work as a belt man, Mr. H. engaged in heavy manual labor. Mr. H. complained about long term shortness of breath. Upon physical examination, Dr. Fino noted decreased breath sounds. According to Dr. Fino, in comparison with earlier radiographic studies, the apparent rapid increase in opacities in the most recent chest x-ray was inconsistent with pneumoconiosis. As a result, he considered the chest x-ray to be negative for pneumoconiosis. The pulmonary function test showed a moderate obstruction. The arterial blood gas study was normal.

Based on the pulmonary testing, Dr. Fino concluded Mr. H. was totally disabled. However, Dr. Fino concluded Mr. H. did not have coal workers' pneumoconiosis and his impairment was not related to coal mine dust exposure because the rapid worsening of his pulmonary condition "long after he left the coal mines is not consistent with a coal mine dust-related pulmonary condition."

Discussion

Dr. Rasmussen found sufficient evidence to diagnose both clinical and legal pneumoconiosis. Dr. Fino disagreed and concluded Mr. H. did not have pneumoconiosis. Due to this conflict in medical opinion, I must first assess the relative probative value of each respective opinion in terms of documentation, reasoning, and medical qualifications.

Regarding the first probative value consideration, documentation, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

Third, a physician who is board certified in the field of pulmonary disease and who has extensive experience in this area may be accorded greater deference because of his or her expertise. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc); *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Burns v. Director, OWCP*, 7 BLR 1-597 (1984).

With these principles in mind, I first note the Dr. Fino's conclusion that Mr. H. does not have clinical pneumoconiosis is documented and reasonably consistent with the most recent radiographic record. However, at the same time, I find that Dr. Fino's conclusion that Mr. H. does not have legal pneumoconiosis has diminished probative value. Having examined Mr. H. in the past and reviewed the medical record, Dr. Fino's assessment on the issue of legal pneumoconiosis is certainly well documented. And, as a board certified pulmonologist, he is well qualified to assess Mr. H.'s pulmonary problems. Nevertheless, his opinion loses probative value due to a significant conflict between his reasoning and the regulatory definition of pneumoconiosis, coupled with two other reasoning shortfalls.

After acknowledging Mr. H.'s worsening pulmonary condition and its rapid onslaught, Dr. Fino eliminates coal mine dust exposure as a possible cause of Mr. H.'s pulmonary obstruction because the decline in pulmonary condition has occurred long after Mr. H. left coal mining in 1986. Such a rationale seems to conflict with the recognition in 20 C.F.R. § 718.201(c) that pneumoconiosis "is recognized as a latent and progressive disease which may first become detectable only after cessation of coal mine dust exposure." As Employer's counsel stressed in his closing brief, the regulatory recognition does not produce a presumption of latency. However, Dr. Fino's elimination of coal dust as a possible etiology is based primarily on Mr. H.'s development of a significant pulmonary impairment long after the cessation of his coal mine employment. Thus, contrary to the regulatory recognition of latency, Dr. Fino appears to maintain that a coal mine dust-related significant obstructive pulmonary impairment can occur only near the cessation of exposure to coal mine dust.

Next, in eliminating coal workers' pneumoconiosis as a possible diagnosis, and other than identifying the increased radiographic opacities as "possible" granulomatous infection, Dr. Fino provides no explanation for Mr. H.'s increased breathing difficulty. The absence of a pulmonary disability etiology diagnosis undermines the reliance that may be placed in Dr. Fino's certainty that Mr. H.'s pulmonary impairment is not related to his coal mine employment.

Finally, during the course of his June 2004 examination of Mr. H., Dr. Fino only conducted a resting blood gas study, with normal results. He then noted that the March 2004 arterial blood gas study which also showed minimal hypoxemia at rest "worsened with exercise."

Significantly, in that summarization, Dr. Fino did not acknowledge that not only did Mr. H.'s hypoxemia become worse upon exertion, the exercise study met the total disability standards. Consequently, in excluding coal mine dust exposure as a cause of Mr. H.'s pulmonary impairment, Dr. Fino did not address a significant component of Mr. H.'s respiratory dysfunction, a totally disabling deficiency of blood oxygenation upon exercise established by the March 2004, February 2005, and March 2005 exercise arterial blood gas studies.

Turning to Dr. Rasmussen's findings, his diagnosis of clinical pneumoconiosis has diminished probative because he based that finding on insufficient documentation. At the conclusion of both pulmonary examinations, Dr. Rasmussen solely relied on Mr. H.'s history of coal mine employment and Dr. Patel's positive interpretations of the March 15, 2004 and February 7, 2005 chest x-rays to find Mr. H. had clinical pneumoconiosis. In rendering his diagnosis, Dr. Rasmussen was not aware of Dr. Wheeler's contrary interpretations which I have determined rendered both films inconclusive for the presence for pneumoconiosis.

At the same time, based on two complete pulmonary evaluations, Dr. Rasmussen's finding of legal pneumoconiosis is well documented and reasoned. Integrating the results of the physical examinations, pulmonary function tests, and exercise arterial blood gas study, Dr. Rasmussen provided a reasoned opinion, identifying Mr. H.'s exposure to coal mine dust as a significant contributing cause of his totally disabling pulmonary obstruction. After indicating that Mr. H.'s two pulmonary risk factors of cigarette smoking and coal mine employment can produce lung tissue damage that can lead to emphysema, Dr. Rasmussen explained that the combination of a pulmonary obstruction, reduced diffusion capacity, and significant blood oxygenation impairment upon exercise established coal mine dust exposure as a principal cause of Mr. H.'s pulmonary impairment. And, while the partial response to bronchodilators seemed inconsistent with the permanent damage caused by pneumoconiosis, Dr. Rasmussen also explained that portion of the test pointed to an additional reactive airways component to Mr. H.'s breathing problems.

Based on the more probative opinion of Dr. Rasmussen, I find Mr. H. has pneumoconiosis. Consequently, Mr. H. has established the presence of pneumoconiosis through probative medical opinion under 20 C.F.R. § 718.202(a)(4).

Correspondingly, based on the more probative medical opinion, Mr. H. has shown a material change in conditions by establishing an element of entitlement previously adjudicated against him in his most recent prior claim. As a result, under 20 C.F.R. § 725.309(d), denial of his subsequent claim based is no longer appropriate. Instead, I will review the entire record to determine whether Mr. H. is able to prove all four elements necessary for entitlement of benefits under the Act; thereby establishing that he is totally disabled due to coal workers' pneumoconiosis. During this process, according to 20 C.F.R. § 725.309(d)(4), "no finding made in connection with the prior claim . . . . shall be binding on any party in the adjudication of the subsequent claim."

Issue #3 – Entitlement to Benefits

Again, to establish entitlement to black lung disability benefits under Act, Mr. H. must prove: a) the presence of pneumoconiosis; b) pneumoconiosis related to coal mine employment; c) total pulmonary disability; and, d) total disability due to coal workers' pneumoconiosis.

Pneumoconiosis

As previously discussed, Mr. H. will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis.

Additional Chest X-Ray Interpretations

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
July 18, 1970	DX 2 & DX 3	Dr. Rosenstein, B	Negative for pneumoconiosis.
Feb. 9, 1971	DX 1	Dr. Adler, BCR, B	Completely negative.
(same)	DX 1	Dr. Cunningham, BCR, B	Positive for pneumoconiosis, profusion category 1, type p opacities.
(same)	DX 1	Dr. Holt, BCR	Negative for pneumoconiosis.
Feb. 7, 1973	DX 1	Dr. Proffitt, BCR, B	Positive for pneumoconiosis, profusion category 3/3, type p opacities.
(same)	DX 1	Dr. Halpern, BCR, B	Completely negative.
(same)	DX 1	Dr. Cunningham, BCR, B	Positive for pneumoconiosis, profusion category 1/0, type p opacities.
Dec. 11, 1973	DX 1	(Unreadable)	Positive for pneumoconiosis, profusion category 2/3, type p opacities.
Feb. 3, 1986	DX 2	Dr. Baxter	Positive for pneumoconiosis, profusion category 2/1, type p/q opacities.
(same)	DX 2	Dr. Sargent, BCR, B	Positive for pneumoconiosis, profusion category 1/0, type s/p opacities.
(same)	DX 2	Dr. Wiot, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type t/q opacities.
(same)	DX 2	Dr. Spitz, BCR, B	Completely negative.
Feb. 4, 1986	DX 2	Dr. Sutherland	Positive for pneumoconiosis, profusion category 3/2, type p opacities.
Sept. 2, 1986	DX 2	Dr. Halbert, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type q/p opacities.
(same)	DX 2	Dr. Anderson	Positive for pneumoconiosis, profusion category 2/2, type p/q opacities.
(same)	DX 2	Dr. Penman	Positive for pneumoconiosis, profusion category 2/2, type p opacities.
(same)	DX 2	Dr. Sargent, BCR, B	Positive for pneumoconiosis, profusion category 1/0, type s/p opacities.
(same)	DX 2	Dr. Wiot, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type t/q opacities.

(same)	DX 2	Dr. Spitz, BCR, B	Completely negative.
Sept. 23, 1986	DX 2	Dr. Modi	Positive for pneumoconiosis, profusion category 2/1, type q opacities.
Sept. 24, 1986	DX 2	Dr. Meyers	Positive for pneumoconiosis, profusion category 2/2, type q/t opacities.
Jan. 13, 1987	DX 2	Dr. Felson, BCR, B	Negative for pneumoconiosis
(same)	DX 2	Dr. Page	Positive for pneumoconiosis, profusion category 1/1, type p opacities.
(same)	DX 2	Dr. Spitz, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type q opacities.
(same)	DX 2	Dr. Wiot, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type t/q opacities.
March 26, 1987	DX 2	Dr. Anderson	Positive for pneumoconiosis, profusion category 2.
April 13, 1987	DX 2	Dr. Lane	Positive for pneumoconiosis, profusion category 1/0, type p opacities.
May 6, 1987	DX 2	Dr. Broudy	Positive for pneumoconiosis, profusion category 1/0, type p/s opacities.
May 18, 1987	DX 2	Dr. Woodring, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type t/s opacities.
(same)	DX 2	Dr. Scott, BCR, B	Negative for pneumoconiosis. Possible emphysema present.
(same)	DX 2	Dr. Wheeler, BCR, B	Negative for pneumoconiosis.
Feb. 1, 1988	DX 2	Dr. Poulos, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type q/p opacities.
(same)	DX 2	Dr. Sargent, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type t/q opacities.
June 30, 1988	DX 2	Dr. Vuskovich, B	Positive for pneumoconiosis, profusion category 1/0, type p opacities.
(same)	DX 2	Dr. Felson, BCR, B	Completely negative.
(same)	DX 2	Dr. Wiot, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type q/t opacities.
(same)	DX 2	Dr. Spitz, BCR, B	Completely negative.
Jan. 4, 1991	DX 2	Dr. Robinette, B	Positive for pneumoconiosis, profusion category 2/1, type q/t opacities.
(same)	DX 2	Dr. Mullins, BCR	Positive for pneumoconiosis.
(same)	DX 2	Dr. Wiot, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type t/q opacities.
(same)	DX 2	Dr. Wheeler, BCR, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Scott, BCR, B	Negative for pneumoconiosis.
April 10, 1991	DX 2	Dr. Hippensteel	Negative for pneumoconiosis, profusion category 0/1, type s/q opacities.
(same)	DX. 2	Dr. Scott, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type p/s opacities. Emphysema present.

(same)	DX 2	Dr. Wheeler, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type q/s opacities. Emphysema present.
(same)	DX 3	Dr. Fino, B	Completely negative.
July 20, 1993	DX 3	Dr. Bassali, BCR, B	Positive for pneumoconiosis, profusion category 2/2, type q/t opacities. Emphysema present.
(same)	DX 3	Dr. Branscomb, B	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities.
(same)	DX 3	Dr. Fino, B	Completely negative.
Oct. 3, 1995	DX 3	Dr. Forehand, B	Positive for pneumoconiosis, profusion category 1/0, type p/t opacities.
(same)	DX 3	Dr. Navani, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type q/t opacities.
(same)	DX 3	Dr. Branscomb, B	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities.
(same)	DX 3	Dr. Scott, BCR, B	Negative for pneumoconiosis. Emphysema present.
(same)	DX 3	Dr. Fino, B	Completely negative.
(same)	DX 3	Dr. Bassali, BCR, B	Positive for pneumoconiosis, profusion category 2/2, type p/s opacities.
(same)	DX 3	Dr. Aycoth, BCR, B	Positive for pneumoconiosis, profusion category 2/3, type q/s opacities.
(same)	DX 3	Dr. Cappiello, BCR, B	Positive for pneumoconiosis, profusion category 2/2, type q/p opacities.
(same)	DX 3	Dr. Pathek, BCR, B	Positive for pneumoconiosis, profusion category 2/2, type p/q opacities. Emphysema present.
Nov. 18, 1995	DX 3	Dr. Vuskovich, B	Completely negative.
(same)	DX 3	Dr. Scott, BCR, B	Negative for pneumoconiosis.
(same)	DX 3	Dr. Wheeler, BCR, B	Negative for pneumoconiosis.
Aug. 19, 1996	DX 3	Dr. Branscomb, B	Positive for pneumoconiosis, profusion category 1/1, type p/s opacities.
(same)	DX 3	Dr. Fino, B	Completely negative.
March 27, 1997	DX 3	Dr. Robinette, B	Positive for pneumoconiosis, profusion category 1/2, type q/t opacities.
(same)	DX 3	Dr. Epling, BCR	Mild interstitial disease.
March 21, 2001	DX 4	Dr. Patel, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities. Emphysema present
(same)	DX 4	Dr. Wiot, BCR, B	Negative for pneumoconiosis. Emphysema present.
Aug. 10, 2001	DX 4	Dr. Fino, B	Completely negative.
(same)	DX 4	Dr. Wheeler, BCR, B	Negative for pneumoconiosis. Emphysema present.

(same)	DX 4	Dr. Scott, BCR, B	Negative for pneumoconiosis. Emphysema present.

Of the 25 additional chest x-rays, no dispute exists concerning over half of the films. Based on the uncontested interpretation(s), the following chest x-rays are positive for pneumoconiosis: December 11, 1973; February 4, 1986; September 23, 1986; September 24, 1986; March 26, 1987; April 13, 1987; May 6, 1987; February 1, 1988; and March 27, 1997. For the same reason, the following chest x-rays are negative for pneumoconiosis: July 18, 1970; April 10, 1991; November 18, 1995; and August 10, 2001.

All the remaining radiographic studies generated a disagreement among the medical professionals who interpreted the films. In the February 9, 1971 chest x-ray, Dr. Adler, a dual qualified radiologist, and Dr. Holt, a board certified radiologist, did not see pneumoconiosis. However, Dr. Cunningham, a dual qualified radiologist, observed pneumoconiosis. Based on their qualifications, I give the assessments of Dr. Adler and Dr. Cunningham the greatest probative weight.[30] Consequently, in light of their professional standoff, I consider the February 9, 1971 chest x-ray inconclusive for pneumoconiosis.

Likewise, due to the dispute between the similarly best qualified physicians, the September 2, 1986 chest x-ray (Dr. Halbert and Dr. Sargent, dual qualified radiologists, read the study positive for pneumoconiosis; Dr. Wiot and Dr. Scott, dual qualified radiologists, read the film negative), the August 19, 1996 chest x-ray (Dr. Branscomb, a B reader, found pneumoconiosis; Dr. Fino, a B reader, did not) and the March 21, 2001 chest x-ray (Dr. Patel, a dual qualified radiologist, considered the film positive for pneumoconiosis; Dr. Wiot interpreted the film as negative) are also inconclusive for the presence of pneumoconiosis.

In the February 7, 1973 chest x-ray, Dr. Proffitt and Dr. Cunningham, dual qualified radiologists, diagnosed the presence of pneumoconiosis. Dr. Halpern, also a dual qualified radiologist, considered the study to be completely negative. Since all three physicians are similarly well qualified, the consensus of Dr. Proffitt and Dr. Cunningham represents the preponderance of the probative medical opinion and establishes that the February 7, 1973 chest x-ray is positive for pneumoconiosis.

The preponderance of the better qualified opinions of Dr. Wiot and Dr. Scott that the February 3, 1986 chest x-ray is negative outweighs the sole positive opinion by Dr. Sargent. As a result, the February 3, 1986 chest x-ray is negative for pneumoconiosis.

The consensus between Dr. Felson and Dr. Scott that the January 13, 1987 chest x-ray is negative for pneumoconiosis outweighs Dr. Wiot's positive interpretation. Consequently, the January 13, 1987 film is negative for pneumoconiosis.

[30]*See Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003) and *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) (greater probative weight may be given to the interpretations of a dual qualified radiologist in comparison to a physician who is only a B reader.)

In a similar manner, the agreement between Dr. Scott and Dr. Wheeler that the May 18, 1987 chest x-ray is negative outweighs the positive interpretation by Dr. Woodring, a dual qualified radiologist. Consequently, the May 18, 1987 chest x-ray is negative.

Since all three dual qualified radiologists, Dr. Felson, Dr. Spitz, and Dr. Wiot, interpreted the study as negative, the June 30, 1988 chest x-ray is negative for pneumoconiosis.

Similarly, the consensus of three dual qualified radiologists, Dr. Wheeler, Dr. Spitz, and Dr. Wiot, outweigh the contrary opinions of Dr. Robinette and Dr. Mullins and establish that the January 4, 1991 film is negative for pneumoconiosis.

As the sole dual qualified radiologist to review the radiographic film, Dr. Bassali's more probative positive interpretation establishes that the July 20, 1993 chest x-ray is positive for pneumoconiosis.

The positive for pneumoconiosis consensus of five dual qualified radiologists, Dr. Navani, Dr. Bassali, Dr. Aycoth, Dr. Cappiello, and Dr. Pathek outweighs the sole contrary interpretation by Dr. Scott. Consequently, the October 3, 1995 chest x-ray is positive for pneumoconiosis.

Finally, in review, I note that I have previously determined that the June 10, 2004 chest x-ray is negative for pneumoconiosis, while the March 15, 2004 and February 7, 2005 films are inconclusive.

Having rendered determinations regarding the respective films, I find that upon consideration of the entire radiographic record before me that the preponderance of the chest x-ray evidence is are positive for pneumoconiosis. Setting aside the 6 inconclusive studies (February 7, 1971; September 2, 1986; August 19, 1996; March 21, 2001; March 15, 2004; and February 7, 2005), 12 of remaining 22 chest x-rays are positive for pneumoconiosis (February 7, 1973; December 11, 1973; February 4, 1986; September 23, 1986; September 24, 1986; March 26, 1987; April 13, 1987; May 6, 1987; February 1, 1988; July 20, 1993; October 3, 1995; and March 27, 1997). Whereas, 10 radiographic studies are negative for pneumoconiosis (July 18, 1970; February 3, 1986; January 13, 1987; May 18, 1987; June 30, 1988; January 4, 1991; April 10, 1991; November 18, 1995; August 10, 2001; and June 10, 2004), Accordingly, based on the preponderance of the radiographic evidence in the entire record, Mr. H. has demonstrated the presence of pneumoconiosis in his lungs under 20 C.F.R. § 718.202(a)(1).

Medical Opinion

Mr. H. has established the presence of pneumoconiosis based on the preponderance of the radiographic evidence, which satisfies the first requisite element of entitlement. However, recognizing that the sufficiency of the radiographic evidence to establish the presence of pneumoconiosis has fluctuated throughout the course of Mr. H.'s numerous claims[31] and

[31]I note that even the interpretations of at least two physicians changed. Dr. Vuskovich saw the presence of pneumoconiosis in the June 30, 1988 chest x-ray and didn't see it in the November 18, 1995 film. Dr. Wiot

considering the numerous inconclusive studies, I believe a review of the medical opinion in this case is also warranted to determine whether Mr. H. can also establish the presence of pneumoconiosis under 20 C.F.R. § 718.202(a)(4).

Dr. Robert F. Baxter
(DX 1)

On April 23, 1980, Dr. Baxter conducted a pulmonary evaluation. Mr. H. complained about shortness of breath. He was a coal miner and had smoked cigarettes for ten years. Upon physical examination, the physician heard rhonchi and course expiration. The arterial blood gas study was normal. Dr. Baxter diagnosed COPD, consistent with coal workers' pneumoconiosis.

Dr. John E. Meyers, Jr.
(DX 2 and DX 3)

On September 24, 1986, Dr. Meyers, board certified in internal medicine, evaluated Mr. H., who presented with shortness of breath complaints. Although the physical examination was normal, the chest x-ray was positive for coal workers' pneumoconiosis and silicosis.[32] The pulmonary function study indicated the presence of a mild obstruction. Dr. Meyers diagnosed coal workers' pneumoconiosis. Due to radiographic evidence of silicosis, Dr. Meyers advised that Mr. H. should not be allowed to return to further dust exposure.

On July 7, 1988, Dr. Meyers indicated Mr. H. had the pulmonary capacity to work as an underground coal miner.

Dr. V. D. Modi
(DX 2)

On January 9, 1987, after indicating that he was Mr. H.'s regular physician, Dr. Modi conducted a pulmonary examination. Mr. H. had 32 years of coal mine employment and a five year history of shortness of breath. The physical examination disclosed coarse rhonchi and wheezes. A chest x-ray from September 23, 1986 was positive for pneumoconiosis. The pulmonary function tests and the arterial blood gas studies were near normal. Dr. Modi diagnosed pulmonary fibrosis due to coal mine dust exposure, COPD, and low back pain. He advised Mr. H. to curtail his exposure to coal mine dust and other noxious fumes. Dr. Modi also indicated Mr. H. could no longer squat, crawl, or lift heavy objects. In Dr. Modi's opinion, Mr. H. was totally and permanently disabled.

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diagnosed the January 13, 1987 radiographic film positive for pneumoconiosis. Yet, in subsequent three films of June 30, 1988; January 4, 1991; and March 21, 2001, Dr. Wiot found insufficient evidence of pneumoconiosis.

[32]Silicosis is considered a form of clinical pneumoconiosis. 20 C.F.R. § 718.201(a)(1).

Dr. Harvey A. Page
(DX 2)

On January 13, 1987, Dr. Page examined Mr. H. who had 32 years of coal mine employment and was a non-smoker. His chest was clear upon physical examination. The chest x-ray was positive for pneumoconiosis. The pulmonary function tests were borderline normal. Dr. Page diagnosed coal workers' pneumoconiosis. Due to the presence of pneumoconiosis, Dr. Page recommended that Mr. H. be removed from dusty work conditions and not be permitted to work in, or around, a dust-related industry.

On July 13, 1988, Dr. Page reviewed previous pulmonary test results and opined that Mr. H. had the respiratory capacity to perform the work of an underground coal miner.

Dr. Robert W. Penman
(DX 2)

On January 24, 1987, Dr. Penman examined Mr. H. who had been a coal miner for 32 years. He also smoked a pack of cigarettes a day for "many" years. Mr. H. reported struggling with shortness of breath for 8 years. He also had a prior back injury. Upon examination, the breath sounds were normal. The chest x-ray was positive for pneumoconiosis. The arterial blood gas study indicated hypoxia. Dr. Penman diagnosed coal workers' pneumoconiosis and opined that Mr. H.'s lung function was impaired.

Dr. William E. Anderson
(DX 2 and DX 3)

On March 26, 1987, Dr. Anderson, board certified in pulmonary disease and internal medicine, conducted an examination. Mr. H. worked 32 years in the coal mines. He had also smoked a pack of cigarettes a day for several years. Upon physical examination, Mr. H.'s lungs were clear. The chest x-ray was positive for pneumoconiosis. The pulmonary function test values for FEV1 and MVV were below normal and indicated a mild pulmonary obstruction. Based on the pulmonary function tests, Dr. Anderson indicated Mr. H. had emphysema associated with his cigarette smoking. Dr. Anderson also diagnosed coal workers' pneumoconiosis.

On February 27, 1991, Dr. Anderson reviewed additional pulmonary testing and noted the test results were well above the thresholds for total disability.

Upon review of the record in July 1991, Dr. Anderson noted that the preponderance of the radiographic record was positive for pneumoconiosis. However, while Mr. H. had coal workers' pneumoconiosis, the pulmonary tests did not support a finding of total disability. Mr. H. also had emphysema associated with his cigarette smoking history.

Dr. Emery Lane
(DX 2 and DX 3)

On April 13, 1987, Dr. Lane, board certified in internal medicine, evaluated Mr. H, who had been a coal miner for 32 years and smoked cigarettes for 20 years at the rate of a pack a day. The physical examination was normal. The chest x-ray was positive for pneumoconiosis. The arterial blood gas study was normal. The pulmonary function test revealed a mild obstructive defect. Dr. Lane diagnosed coal workers' pneumoconiosis and COPD. The physician attributed the obstructive pulmonary impairment to Mr. H.'s history of cigarette smoking.

On June 14, 1988, having reviewed his pulmonary evaluation of Mr. H., Dr. Lane concluded that Mr. H. had the respiratory capacity to perform the work of a coal miner.

In June 1990, after a medical record review, Dr. Lane opined Mr. H. was not totally disabled. The physician also noted the improvement in the test results indicated the obstruction was due to cigarette smoking.

In January, February, and July 1991, after reviewing various documents, Dr. Lane again noted the absence of any significant pulmonary impairment. The physician believed Mr. H. had the respiratory capacity to mine coal. Mr. H. had pulmonary emphysema associated with "his long history of cigarette smoking."

On February 27, 1991, Dr. Lane reviewed additional medical record. In his opinion, while Mr. H. had coal workers' pneumoconiosis, he did not suffer a significant pulmonary impairment.

Dr. Bruch C. Broudy
(DX 2 and DX 3)

On May 6, 1987, Dr. Broudy, board certified in pulmonary and internal medicine, evaluated Mr. H.'s pulmonary health. Mr. H. had been a coal miner for 32 years who also smoked cigarettes for up to 20 years at the rate of one pack per day. He presented with chronic shortness of breath. Upon physical examination, the chest was clear. The chest x-ray was positive for pneumoconiosis. The arterial blood gas study showed borderline hypoxemia at rest. The pulmonary function tests revealed a mild airways obstruction, which Dr. Broudy attributed to cigarette smoking. Dr. Broudy diagnosed coal workers' pneumoconiosis and mild obstructive airways disease. However, in his opinion, Mr. H. was not totally disabled.

On August 2, 1996, Dr. Broudy reviewed the arterial blood gas test results from Dr. Forehand's October 1995 pulmonary evaluation. While Mr. H. had significant resting hypoxemia, Dr. Broudy believed the short duration of the exercise portion of the test was attributable to some reason other than poor blood oxygenation.

Dr. James K. Cooper
(DX 2 and DX 3)

On May 18, 1987, Dr. Cooper, board certified in internal medicine, conducted a pulmonary evaluation. Mr. H. reported 32 years of coal mine employment. He had smoked a pack of cigarettes a day between the ages of 15 and 34. He had trouble breathing. The physical examination was normal. The arterial blood gas study showed mild resting hypoxemia. No significant restrictive disease was present in the pulmonary function test. The chest x-ray was positive for pneumoconiosis. Dr. Cooper diagnosed coal workers' pneumoconiosis. However, Mr. H. retained the respiratory capacity to return to coal mine employment.

Dr. R. V. Mettu
(DX 2 and DX 3)

On February 1, 1988, Dr. Mettu, board certified in internal medicine, examined Mr. H. Mr. H. reported 32 years of coal mine employment and 18 years of smoking one pack of cigarettes a day; he stopped in 1970. The physical examination and arterial blood gas study were normal. The chest x-ray was positive for pneumoconiosis The pulmonary function test showed a mild obstructive impairment. Dr. Mettu diagnosed chronic bronchitis and coal workers' pneumoconiosis. In his opinion, Mr. H. had the respiratory capacity to do work similar to coal mine employment in a dust-free environment.

Dr. Matt Vuskovich
(DX 2 and DX 3)

On June 30, 1988, Dr. Vuskovich conducted a pulmonary evaluation. Mr. H. reported shortness of breath upon exertion. He had mined coal for 32 years and smoked a pack of cigarettes a day for about 18 years. The physical examination disclosed persistent rales at the lung bases. The pulmonary function tests was near normal and the arterial blood gas study was normal. The chest x-ray was positive for pneumoconiosis. Dr. Vuskovich diagnosed simple coal workers' pneumoconiosis. At the same time, Mr. H. did not have a pulmonary or respiratory impairment.

On September 9, 1991, Dr. Vuskovich reviewed the medical record. The preponderance of the evidence established that Mr. H. had simple coal workers' pneumoconiosis. Mr. H. had also developed a mild obstructive pulmonary impairment associated with his 22 pack year history of cigarette smoking. Mr. H. retained the respiratory capacity to return to coal mining.

On November 18, 1995, Dr. Vuskovich again examined Mr. H. He heard wheezes upon physical examination. The chest x-ray was normal. The pulmonary function test indicated a mild obstructive impairment. Based on the pulmonary tests, Dr. Vuskovich diagnosed COPD due to cigarettes. Mr. H. did not have pneumoconiosis and was not totally disabled.

In a February 12, 1996 deposition, Dr. Vuskovich reiterated the findings of his November 18, 1995 pulmonary evaluation. The physician believed Mr. H.'s obstructive impairment was caused by cigarette smoking because the obstruction involved the bronchial tree rather than the

lung parenchyma. Mr. H. was not totally disabled. Although Dr. Vuskovich interpreted a 1988 chest x-ray as positive for pneumoconiosis, he believed the 1995 film was negative for pneumoconiosis. Consequently, the disease noted in the earlier chest x-ray was a "non-occupational condition." Mr. H. did not have coal workers' pneumoconiosis.

Dr. Emory H. Robinette
(DX 2 and DX 3)

On January 4, 1991, Dr. Robinette, board certified in pulmonary and internal medicine, conducted a pulmonary exam. Mr. H. worked 32 years as a coal miner. He had a 15 pack year history of cigarette smoking. The physical examination revealed expiratory wheezes. The chest x-ray was positive for pneumoconiosis. The pulmonary function test indicated a mild obstruction without response to bronchodilator medication. The arterial blood gas study revealed mild resting hypoxemia. Dr. Robinette diagnosed coal workers' pneumoconiosis and industrial bronchitis. According to Dr. Robinette, Mr. H. was totally disabled due to a significant pulmonary impairment.

On August 8, 1991, Mr. H. underwent a cardio-pulmonary stress test. Based on the test, Dr. Robinette concluded "there is evidence of a mild respiratory impairment for the level of exercise performed."

On July 26, 1996, Dr. Robinette reviewed the medical record from 1973 to 1991. In his opinion, the chest x-rays showed abnormalities consistent with pneumoconiosis. However, Mr. H. was not totally disabled.

On March 20, 1997, Dr. Robinette reviewed the medical record from 1991 to 1995 and noted a marked deterioration in Mr. H.'s lung function. When Mr. H. was evaluated before 1991, the tests were insufficient to establish total disability. However, the most recent arterial blood gas studies established total disability.

On March 27, 1997, Dr. Robinette reevaluated Mr. H. On physical examination, Dr. Robinette heard wheezes and crackles. The chest x-ray was positive for pneumoconiosis. The pulmonary function study showed a moderate pulmonary obstruction. The arterial blood gas study indicated resting hypoxemia and an inappropriate response to exercise. Also noting that Dr. Forehand's examination produced similar results, Dr. Robinette concluded Mr. H. was totally disabled due to coal workers' pneumoconiosis.

Dr. Greg J. Endes-Bercher
(DX 2)

On April 10, 1991, Dr. Endes-Bercher evaluated Mr. H. Mr. H.'s coal mining career covered 32 years. He had smoked a pack of cigarettes a day for nearly 30 years. Mr. H. reported long term shortness of breath. The physical examination and arterial blood gas study were normal. The chest x-ray was negative for pneumoconiosis. The pulmonary function study showed a mild obstructive impairment attributable to cigarettes. Dr. Endes-Bercher concluded Mr. H. did not have pneumoconiosis and was not totally disabled.

Dr. Gregory J. Fino
(DX 2, DX 3, and DX 4)

On August 19, 1991, Dr. Fino, board certified in pulmonary disease and internal medicine, reviewed the medical record. While he believed Mr. H. had coal workers' pneumoconiosis based on the preponderance of the radiographic evidence, Dr. Fino concluded Mr. H. had "no pulmonary disability whatsoever." Mr. H. had a mild obstructive impairment that was clinically insignificant.

On August 20, 1996, Dr. Fino examined Mr. H. who had 32 years of coal mine employment. Mr. H. also claimed to have smoked a half a pack of cigarettes a day for 15 years. He complained about worsening shortness of breath. The physical examination was normal and the chest x-ray was completely negative. The pulmonary function tests showed a moderate pulmonary obstruction, which did not respond to bronchodilators. The resting arterial blood gas study indicated mild hypoxia. Based on his examination and a review of additional medical records, Dr. Fino concluded that Mr. H. did not have coal workers' pneumoconiosis and was not totally disabled. The type of obstruction identified by the pulmonary function testing was consistent with cigarette smoking and emphysema rather than exposure to coal mine dust. The mild hypoxia was not totally disabling and the varying arterial blood gas studies were inconsistent with the permanent damage caused by pneumoconiosis.

On August 11, 2001, Fino conducted another pulmonary examination. The physical examination and arterial blood gas were normal. The chest x-ray was negative for pneumoconiosis. The pulmonary function study revealed a moderate pulmonary obstruction that did not respond to bronchodilators and had worsened since the previous evaluation. In Dr. Fino's opinion, Mr. H. did not have coal workers' pneumoconiosis and he was not totally disabled.

Dr. J. Randolph Forehand
(DX 3)

On October 3, 1995, Dr. Forehand conducted a pulmonary examination. Mr. H. had 32 years of coal mine employment and 15 years of smoking a half of pack of cigarettes a day. The physical examination was normal. The chest x-ray was positive for pneumoconiosis. The pulmonary function study revealed an obstructive impairment. The arterial blood gas study indicated hypoxemia. Based on his examination, Dr. Forehand diagnosed coal workers' pneumoconiosis and chronic bronchitis, attributable to cigarette smoking. In light of the arterial blood gas studies, Mr. H. was totally disabled due to coal workers' pneumoconiosis.

Dr. John A. Michos
(DX 3)

Based on a limited record review on January 31, 1996, Dr. Michos concluded Mr. H. had simple coal workers' pneumoconiosis. Mr. H. was also totally disabled due to cigarettes in light of the "minimal" profusion of pneumoconiosis in the chest x-rays.

Dr. Keith W. Chandler
(DX 3)

On June 13, 1996, Dr. Chandler, board certified in pulmonary disease and internal medicine, reviewed Mr. H.'s medical record from 1985 and 1986. Since the preponderance of the radiographic evidence was negative, Dr. Chandler opined Mr. H. did not have coal workers' pneumoconiosis. Although Mr. H. had a mild airflow obstruction, the impairment did not preclude his return to coal mine employment. Mr. H.'s pulmonary obstruction was due to his past cigarette smoking and not his exposure to coal mine dust.

Dr. Frank J. Sutherland
(DX 3)

On May 16, 1996, Dr. Sutherland, Mr. H.'s treating physician, indicated that Mr. H has coal workers' pneumoconiosis. In his opinion, Mr. H. no longer retained the pulmonary capacity to return to coal mine employment. His pulmonary disability was due to his coal workers' pneumoconiosis. Dr. Sutherland prescribed several inhalers and an aerosol machine for Mr. H.

On January 31, 1997, Dr. Sutherland opined that Mr. H. had coal workers' pneumoconiosis. Additionally, his pulmonary condition had progressively worsened such that Mr. H. was totally disabled.

Dr. Ben V. Branscomb
(DX 3)

On September 16, 1996, Dr. Branscomb, board certified in internal medicine, conducted a medical record review from 1987 to 1995. Mr. H. had 32 years of coal mine employment. His cigarette smoking history varied from 15 to 29 years at the rate of one-half to one pack of cigarettes a day. The radiographic record produced mixed interpretations. Based on his review of several chest x-rays, Dr. Branscomb believed Mr. H. had early, simple coal workers' pneumoconiosis. The pulmonary function studies consistently established the presence of a reversible, mild obstructive airways pulmonary defect. Most of the arterial blood gas studies were normal. Although the most recent arterial blood gas study met the total disability threshold, Dr. Branscomb questioned its validity. Even if the most recent arterial blood gas study were valid, totally disabling impairment would not be related to Mr. H.'s exposure to coal mine dust. No scientific evidence exists that shows a connection between low oxygenation capacity and the presence of simple, profusion 1 coal workers' pneumoconiosis. As a result, Mr. H. did not have a totally disabling pulmonary impairment due to coal mine dust exposure.

In a November 1, 1996 deposition, Dr. Branscomb again indicated that while the interpretations of other physicians varied, he believed Mr. H. had radiographic evidence of pneumoconiosis. The physician also noted the pulmonary function studies consistently indicated the presence of a mild pulmonary obstruction. Since Mr. H. left coal mining long before developing the mild COPD, Dr. Branscomb did not attribute the impairment to his exposure to coal mine dust. If valid, the most recent arterial blood gas studies showed a totally disabling oxygenation insufficiency. Since Mr. H. only has early, simple coal workers' pneumoconiosis,

the abnormal blood gas studies were not related to his exposure to coal mine dust. According to Dr. Branscomb, the simple pneumoconiosis had not caused sufficient fibrosis in Mr. H.'s lungs to be the cause of his arterial blood gas impairment.

Dr. D. L. Rasmussen
(DX 4)

On March 21, 2001, Dr. Rasmussen evaluated Mr. H.'s pulmonary health. Mr. H. had 32 years of coal mine employment. He smoked half a pack of cigarettes per day for 22 years, stopping in 1978. Mr. H. struggled with long term shortness of breath upon exertion. Upon physical examination, Dr. Rasmussen heard bilateral rales. The chest x-ray was positive for pneumoconiosis. The pulmonary function tests showed a slightly reversible, minimal obstructive pulmonary defect. Upon exercise, Mr. H.'s arterial blood gas test was abnormal, indicating a moderate impairment in blood oxygenation. Based on the positive chest x-ray and Mr. H.'s long history of coal mine employment, Dr. Rasmussen opined that he had coal workers' pneumoconiosis. The physician also diagnosed COPD/emphysema that was caused both by cigarette smoking and exposure to coal mine dust. Because Mr. H. suffered a moderate loss of lung function, he was totally disabled. His impairment was due to cigarette smoking and exposure to coal mine dust. Coal mine dust was a major contributing factor to Mr. H.'s impairment.

Discussion

The overwhelming preponderance of the medical opinion supports a finding of clinical pneumoconiosis. With the exception of Dr. Sutherland's opinion, which is essentially undocumented, the following physicians presented documented and reasoned conclusions, consistent with the positive chest x-rays before them and my determination, that Mr. H. has clinical pneumoconiosis: Dr. Baxter (1980), Dr. Meyers (1986), Dr. Modi (1987), Dr. Page (1987), Dr. Penman (1987), Dr. Anderson (1987), Dr. Lane (1987), Dr. Broudy (1987), Dr. Cooper (1987), Dr. Mettu (1988), Dr. Robinette (1991 to 1997), Dr. Forehand (1995), Dr. Michos (1996), Dr. Branscomb (1996), and Dr. Rasmussen (2001 to 2005) concluded that Mr. H. had pneumoconiosis. The contrary opinions of Dr. Endes-Bercher (1991), Dr. Chandler (1996), Dr. Vuskovich (1988 to 1996) and Dr. Fino (1991 to 2004) that Mr. H. does not have clinical pneumoconiosis have diminished probative value since they relied on negative chest x-ray findings, which is contrary to my determination that the radiographic evidence is positive for pneumoconiosis.

On the other hand, joining Dr. Endes-Bercher, Dr. Chandler, Dr. Vuskovich, and Dr. Fino, several of physicians who diagnosed clinical pneumoconiosis at the same time concluded that Mr. H. did not have legal pneumoconiosis. Based on the pulmonary tests, Dr. Lane, Dr. Broudy, Dr. Forehand, and Dr. Branscomb opined that Mr. H.'s pulmonary impairment was attributable to cigarette smoking and not coal mine dust exposure. In contrast, only one physician, Dr. Rasmussen, diagnosed legal pneumoconiosis by finding that coal mine dust exposure was a major contributing cause of Mr. H.'s pulmonary impairment.

In assessing the probative value of the respective opinions on the etiology Mr. H.'s pulmonary impairment, the assessments of all but two doctors have diminished probative value due to the dated nature of their underlying documentation. Specifically, in 1987, when Dr. Lane and Dr. Broudy found no causation link between Mr. H.'s pulmonary obstruction and his coal mine employment, the severity of Mr. H.'s pulmonary obstructive defect was much less than present and his blood oxygenation was near normal. Similarly, between 1991 and 1997, Dr. Endes-Bercher, Dr. Forehand, Dr. Chandler, Dr. Vuskovich, and Dr. Branscomb were obviously unaware of the nature and extent of Mr. H.'s pulmonary problems in 2004 and 2005. Of the two physicians who aware of Mr. H.'s present pulmonary condition, I have already determined that Dr. Rasmussen's determination of legal pneumoconiosis is more probative and outweighs Dr. Fino's contrary conclusion. Accordingly, in light of the diminished probative value of the earlier medical opinions and the greater probative weight of Dr. Rasmussen's diagnosis of legal pneumoconiosis, Mr. H. is able to also establish the presence of legal pneumoconiosis.

Accordingly, Mr. H. has demonstrated the presence of both clinical and legal pneumoconiosis in his lungs under 20 C.F.R. § 718.202(a)(4).

Pneumoconiosis Arising Out of Coal Mine Employment

Once a claimant has proven the existence of pneumoconiosis, 20 C.F.R. § 718.203(a) requires that he also establish that his pneumoconiosis arose at least in part from his coal mine employment. According to 20 C.F.R. § 718.203(b), if the claimant was employed in coal mining for ten or more years, a rebuttable presumption exists that the pneumoconiosis is due to coal mine employment.

As previously noted, the Employer has stipulated that Mr. H. had at least 24 years of coal mine employment. Consequently, a regulatory presumption is established that Mr. H's pneumoconiosis was related to his coal mine employment. In the evidentiary record before me, I find little evidence exists to rebut that presumption in regards to clinical pneumoconiosis. In terms of legal pneumoconiosis, as previously noted, the earlier medical opinions, as well as Dr. Fino's findings, have diminished probative value on whether Mr. H.'s pulmonary impairment is related to his coal mine employment. Consequently, based on the un-rebutted presumption under 20 C.F.R. § 718.203(b), I find Mr. H. has coal workers' pneumoconiosis.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204(b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204(b)(1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, that to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

The record does not contain sufficient evidence that Mr. H. has complicated pneumoconiosis and he has not presented evidence of cor pulmonale with right-sided congestive heart failure. As a result, Mr. H. must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.[33]

Pulmonary Function Tests[34]

Exhibit	**Date / Doctor**	**Age / Height**	**FEV_1 pre[35] post[36]**	**FVC pre post**	**MVV pre post**	**% FEV_1 / FVC pre post**	**Qualified[37] pre post**	**Comments**
DX 1	April 7, 1973	37 69”	3.16	4.46	145	70%	No	
DX 2	Sept. 10, 1986 Dr. Modi	50 (69”)[38]	2.92 2.95	4.63 4.67	---	63% 62%	No No	
DX 2	Sept. 24, 1986 Dr. Meyers	50 69”	2.70	4.40	72	61%	No	
DX 2	Jan. 13, 1987 Dr. Page	51 (69”)[39]	2.13 3.38	3.63 4.96	68 155	58% 68%	No No	
DX 2	Jan. 25, 1987 Dr. Penman	51 69”	2.35	3.90	---	60%	No	
DX 2	April 13, 1987 Dr. Lane	51 69”	2.35	4.425	120	53%	No	

[33]To facilitate the evaluation of the pulmonary tests, I include the previously summarized tests associated with the Mr. H.’s present claim in the following summaries.

[34]I have not included Dr. Anderson’s March 26, 1987 pulmonary function test since the specific measurements were not provided.

[35]Test result before administration of a bronchodilator.

[36]Test result following administration of a bronchodilator.

[37]Under 20 C.F.R. § 718.204 (b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner’s age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[38]Although Dr. Modi reported Mr. H.’s height as 70”, I have applied 69”, consistent with the preponderance of the other pulmonary function test measurements.

[39]Although Dr. Page reported Mr. H.’s height as 71”, I have applied 69”.

DX 2	May 6, 1987 Dr. Broudy	51 69”	2.48	4.37	126	56%	No	
DX 2	May 18, 1987 Dr. Cooper	51 69”	2.13	4.51	125	58%	No	
DX 2	Feb. 1, 1988 Dr. Mettu	52 69”	2.57	4.85	90.9	53%	No	
DX 2	June 30, 1988 Dr. Vuskovich	52 (69”)[40]	2.60	4.04	116	64%	No	
DX 2	Jan. 4, 1991 Dr. Robinette	55 69” 	2.53 2.42	4.66 4.47	---	54% 54%	No No	
DX 2	Apr. 10, 1991 Dr. Endes-Bercher	55 69”	2.55 2.71	4.54 4.84	123 144	56% 56%	No No	
DX 3	Oct. 3, 1995 Dr. Forehand	59 69”	2.08 2.27	3.71 3.89	100 119	56% 58%	No No	
DX 3	Nov. 18, 1995 Dr. Vuskovich	59 69”	2.38	4.21	---	57%	No	
DX 3	May 6 1996 Dr. Sutherland	60 69”	2.16	3.87	51	56%	No	Invalid per Dr. Fino
DX 3	Aug. 20, 1996 Dr. Fino	60 69”	2.31 2.44	4.44 4.67	94 100	52% 52%	No No	
DX 3	Mar. 27, 1997 Dr. Robinette	61 69”	2.08 2.30	4.45 4.83	----	47% 48%	No No	
DX 4	Mar. 21, 2001 Dr. Rasmussen	65 69”	2.20 2.40	4.58 4.85	78 97	48% 49%	No No	
DX 4	Aug. 10, 2001 Dr. Fino	65 69”	2.13 2.14	4.20 4.20	---	51% 51%	No No	
DX 14	March 15, 2004 Dr. Rasmussen	68 69”	1.60 1.90	3.73 3.95	--	44% 48%	Yes No	
EX 3	June 10, 2004 Dr. Fino	68 69”	1.61 1.92	3.23 3.49	--	50% 55%	Yes No	
CX 1	Feb. 7, 2005 Dr. Rasmussen	69 69”	1.27 1.61	3.34 3.89	--	38% 41%	Yes Yes	

Under the provisions of 20 C.F.R. § 718.204(b)(2)(i), if the preponderance of pulmonary function tests qualify under Appendix B of Section 718, then in the absence of evidence to the contrary, the pulmonary tests shall establish a miner’s total disability. This regulatory scheme requires a five step process. First, an administrative law judge must determine whether the tests conform to the procedural requirements in 20 C.F.R. § 718.103. Second, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. *See Vivian v. Director, OWCP [Alley]*, 897 F.2d 1045 (10th Cir. 1990). Concerning validity, more weight may be given to the observations of technicians who administered the tests than the doctor who reviewed the tracings. *Revnack v. Director, OWCP*, 7 B.L.R. 1-771 (1985). As a result, if an administrative law judge credits the reviewing doctor’s opinion over the technician who actually observed the test, he must provide a rationale. *Brinkley v. Peabody Co*., 14 B.L.R. 1-147 (1990). Third, the test results are compared to the qualifying numbers listed in Appendix B to determine whether the tests show total disability. Fourth, a determination must be made whether the preponderance of the conforming and valid pulmonary function tests supports a finding of total disability under the regulation. In that regard, more probative weight may be

[40]Although Dr. Vuskovich, reported Mr. H.’s height as 70”, I have applied 69”.

given to the results of a more recent study over those of an earlier test. *Coleman v. Ramey Coal Co*., 18 B.L.R. 1-9 (1993). Fifth, if the preponderance of conforming tests establishes total disability under the regulation, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, it must be given appropriate evidentiary weight and a determination is then made to see if it outweighs the pulmonary function test evidence that supports a finding of total respiratory disability. *Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19, 1-21 (1987).

In Mr. H.'s case, all the pulmonary function tests appear to be conforming. Other than Dr. Fino's assessment that the May 6, 1996 test is invalid, the remaining 21 tests also appear to be valid. Next, while the preponderance of the valid studies, 18 of 21, did not reach the regulatory total disability thresholds, the three most recent evaluations from 2004 and 2005 demonstrate that Mr. H. has become totally disabled. Thus, based on the three recent, conforming, and valid pulmonary function studies, Mr. H. may be able to establish total disability through pulmonary function test evidence, absent evidence to the contrary.

Other Medical Evidence

As the final step in determining whether the preponderance of the pulmonary function tests establishes total disability, I must consider other recently developed medical tests and opinion that may be contrary evidence and then render a probative value assessment.

Chest X-Rays

The extensive radiographic evidence in this claim, standing alone, does not provide contrary evidence since the chest x-rays do not establish the extent of disability.

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**$_pCO_2$ (rest)** **$_pCO_2$ (exercise)**	**$_pO_2$ (rest)** **$_pO_2$ (exercise)**	**Qualified**	**Comments**
DX 1	April 23, 1980 Dr. Baxter	39.1	83.2	No	
DX 2	Sep. 11, 1986 Dr. Modi	36.9	81.7	No	
DX 2	January 24, 1987 Dr. Penman	39.8	69.6	No	
DX 2	March 26, 1987 Dr. Anderson	38	69	No	
DX 2	April 13, 1987 Dr. Lane	36	81	No	
DX 2	May 6, 1987 Dr. Broudy	35.6	79.1	No	
DX 2	May 18, 1987 Dr. Cooper	35.8 36.3	70 82.5	No No	
DX 2	Feb. 1, 1988 Dr. Mettu	37.7	85	No	
DX 2	June 30, 1988 Dr. Vuskovich	35.5	77.3	No	

DX 2	Jan. 4, 1991 Dr. Robinette	37.2	71	No	
DX 2	Apr. 10, 1991 Dr. Endes-Bercher	34.4 31.9	81.1 86.9	No No	
DX 3	Oct. 3, 1995 Dr. Forehand	31 33	64 59	Yes[41] Yes[42]	Validity questioned by Dr. Branscomb.
DX 3	August 19, 1996 Dr. Fino	38	68	No	
DX 3	Mar. 27, 1997 Dr. Robinette	36.2 39.4	75 72	No No	
DX 4	Mar. 21, 2001 Dr. Rasmussen	35 35	69 64	No Yes[43]	
DX 4	Aug. 10, 2001 Dr. Fino	38.7	71.2	No	
DX 14	March 15, 2004 Dr. Rasmussen	36 39	69 58	No[44] Yes[45]	
EX 3	June 10, 2004 Dr. Fino	38.2	72.7	No[46]	
CX 1	Feb. 7, 2005 Dr. Rasmussen	38 42	70 57	No Yes[47]	
CX 2	May 18, 2005 Dr. Castle	38.8 35.1	71.7 56.6	No Yes[48]	

The sheer preponderance of the arterial blood gas studies did not meet the total disability thresholds. However, in a pattern similar to the pulmonary function tests, the more recent arterial blood studies demonstrate that Mr. H.'s ability to sufficiently oxygenate his blood upon exertion has become significantly impaired. Specifically, since March 2001, all four exercise arterial blood gas studies have met the regulatory total disability standards. Obviously, the more recent exercise arterial blood gas studies do not represent contrary evidence on the issue of total disability. In fact, the four most recent exercise arterial blood gas studies establish total disability under 20 C.F.R. § 718.204(b)(2)(ii).

[41]For a pCO^2 of 31, the qualifying pO^2 is 69, or less.

[42]For a pCO^2 of 39, the qualifying pO^2 is 67, or less.

[43]For a pCO^2 of 35, the qualifying pO^2 is 65, or less.

[44]For a pCO^2 of 36, the qualifying pO^2 is 64, or less.

[45]For a pCO^2 of 39, the qualifying pO^2 is 61, or less.

[46]For a pCO^2 of 38, the qualifying pO^2 is 62, or less.

[47]For a pCO^2 of 40 to 49, the qualifying pO^2 is 60, or less.

[48]For a pCO^2 of 35, the qualifying pO^2 is 65, or less.

Medical Opinion

Both physicians who were aware of the 2004 and 2005 pulmonary function tests, Dr. Rasmussen and Dr. Fino, concluded that Mr. H. was totally disabled. Consequently, the medical opinion is consistent with, rather than contrary to, the preponderance of the most recent pulmonary function tests showing total disability.

Conclusion

Accordingly, based on the preponderance of the three most recent pulmonary function tests, and in the absence of contemporaneous contrary evidence, I find that Mr. H. is totally disabled pursuant to the provisions of 20 C.F.R. §718.204(b)(2)(i). Similarly, based on the preponderance of the four most recent exercise arterial blood gas studies, and in the absence of probative contrary evidence, I find Mr. H. is also totally disabled pursuant to 20 C.F.R. § 718.204(b)(2)(iii).

Total Disability Due to Coal Workers' Pneumoconiosis

Since Mr. H. has established three of the four requisite elements for entitlement to benefits, the award of benefits rests on the determination of whether his respiratory disability is due to coal workers' pneumoconiosis. Proof that a claimant has a totally disabling pulmonary disease does not by itself establish the impairment is due to pneumoconiosis. Pursuant to 20 C.F.R. § 718.204(c)(1), absent a favorable regulatory presumption,[49] the claimant must demonstrate that pneumoconiosis was a substantially contributing cause of his total disability by showing the disease: 1) had a material, adverse effect on his respiratory or pulmonary condition; or 2) materially worsened a totally disabling respiratory impairment caused by a disease or exposure unrelated to pneumoconiosis. Additionally, 20 C.F.R. § 718.204(c)(2) mandates that "the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report."

As previously discussed, for various reasons, almost all of the medical opinion developed in the past 25 years has little probative value on the nature of Mr. H.'s present totally disabling pulmonary impairment. First, none of the doctors who evaluated Mr. H. from 1980 to 1988 (Dr. Baxter, Dr. Meyers, Dr. Modi, Dr. Page, Dr. Penman, Dr. Anderson, Dr. Lane, Dr. Broudy, Dr. Cooper, Dr. Mettu, and Dr. Vuskovich) opined that he was totally disabled due to a pulmonary impairment. Similarly, Dr. Endes-Bercher in 1991 and Dr. Chandler in 1996 did not believe Mr. H. was totally disabled.

Next, although Dr. Forehand (1991) and Dr. Sutherland (1996-1997) concluded that Mr. H. was totally disabled by pneumoconiosis, neither physician provided any explanation for their

[49]20 C.F.R. § 718.305 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption the claimant is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more of coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and, 20 C.F.R. § 718.306 (a presumption exists when a survivor files a claim prior to June 30, 1982).

etiology determinations. Absent sufficient reasoning, their causation opinions carry little probative weight.

In 1996, both Dr. Michos and Dr. Branscomb attributed Mr. H.'s pulmonary impairment to his history of cigarette smoking because the chest x-rays only showed the presence of simple pneumoconiosis. As explained by Dr. Branscomb, simple coal workers' pneumoconiosis would not cause an oxygenation deficiency because it does not produce sufficient fibrosis to adversely affect that lung function. Although both opinions are reasoned, I note that at the time of their assessments, Mr. H.'s pulmonary function tests had not reached totally disabling thresholds. As a result, again due to the dated nature of their evaluations, these two physicians were unaware of the deterioration in Mr. H.'s pulmonary function and thus were not able to address whether the development of a totally disabling obstructive impairment would alter their etiology assessment. I also note that Dr. Branscomb additionally supported his opinion by stressing Mr. H. developed a pulmonary impairment (albeit mild at the time of his evaluation) long after leaving coal mining. As I have previously discussed, the exclusion of coal mine dust from consideration as a cause of a pulmonary obstruction on that basis seems inconsistent with the regulatory recognized potential latency of pneumoconiosis.

Finally, I turn to the two physicians who are aware of Mr. H.'s present pulmonary condition, Dr. Rasmussen and Dr. Fino. In previously adjudicating the issue of legal pneumoconiosis, I have already determined that Dr. Fino's conclusion that Mr. H.'s pulmonary impairment is not due to his exposure to coal mine dust has diminished probative value. In contrast, Dr. Rasmussen provided a well documented and reasoned opinion delineating three specific aspects of the objective medical evidence which supported his determination that Mr. H. was totally disabled due to coal workers' pneumoconiosis. Accordingly, based on Dr. Rasmussen's probative assessment, I find Mr. H. has established total disability due to coal workers' pneumoconiosis under 20 C.F.R. § 718.204(c).

CONCLUSION

Based on the probative opinion of Dr. Rasmussen, Mr. H. has established the presence of legal pneumoconiosis, thereby establishing a change in condition of entitlement previously adjudicated against him as required by 20 C.F.R. § 725.309 (d). Upon consideration of the entire record, I find that Mr. H. is totally disabled due to coal workers' pneumoconiosis. Accordingly, Mr. H.'s claim for black lung disability benefits must be approved.

Date of Entitlement

Under 20 C.F.R. § 725.503(b), in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total pulmonary disability. When the evidence does not establish when the onset of total disability occurred, benefits are payable starting the month the claim was filed. The BRB has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the

claim was filed. The BRB also stated in *Johnson*, "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example is the situation in *Rochester and Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989), where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam, the miner became totally disabled. *See Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is "first able to muster evidence of total disability is not necessarily the date of onset").

Finally, according to 20 C.F.R. § 725.309(d)(5), when an award is made in a subsequent claim, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

Mr. H.'s prior claim was finally denied in November 2002 and he filed his present subsequent claim in January 2004. No medical evidence has been presented for the time period between November 2002 and January 2004. Additionally, the record contains no evidence to establish an identifiable period of time between January 2004 and Dr. Rasmussen's pulmonary evaluation in March 2004 during which Mr. H. was not totally disabled due to coal workers' pneumoconiosis. Consequently, I find the appropriate date of entitlement is January 1, 2004.

Augmentation

Since the parties have stipulated that Mrs. G. H. is a dependent for purposes of augmenting any benefits that may be payable under the Act, Mr. H.'s entitlement will be augmented for his spouse.

Attorney Fees

Counsel for the Claimant has thirty calendar days from receipt of this decision and order to submit an application for attorney fees in accordance with 20 C.F.R. §§ 725.365 and 725.366. With the application, counsel must attach a document showing service of the fee application upon all parties, including the Claimant. The other parties have fifteen calendar days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with this claim.

ORDER

The motion to dismiss Mr. H.'s fifth, and present, claim due to un-timeliness is **DENIED**.

The claim of MR. O. R. H. is **GRANTED**. The Employer, BLUE STAR COAL CORPORATION, is ordered to:

1. Pay Mr. O. R. H. all benefits to which he is entitled under the Act and Regulations, augmented for his dependent spouse, Mrs. G. H. Benefits shall commence January 1, 2004;

2. Reimburse the Black Lung Disability Trust Fund, pursuant to 20 C.F.R. § 725.602(a), for all interim payments made by the Black Lung Disability Trust Fund to Mr. O. R. H.;

3. Deduct from the payments ordered in paragraph one, as appropriate, the amounts reimbursed to the Black Lung Disability Trust Fund as directed in paragraph two; and

4. Pay to the Secretary of Labor interest as required pursuant to 20 C.F.R. § 725.608(b).

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: September 22, 2006
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and

the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).